KAMALA D. HARRIS
Attorney General of California
JANICE K. LACHMAN
Supervising Deputy Attorney General
KENT D. HARRIS
Deputy Attorney General
State Bar No. 144804
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-7859
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **PEGGY LEE MARTIN,** **aka PEGGY LEE DENMAN** **2039 E. Beech Avenue** **Visalia, CA 93292** **Registered Nurse License No. 504023** Respondent.	Case No. 2013 - 567 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about September 16, 1994, the Board issued Registered Nurse License Number 504023 to Peggy Lee Martin, also known as Peggy Lee Denman ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2014, unless renewed.

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STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

6. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

7. Regulation 1443 states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being

renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. At all times relevant to the charges brought herein, Respondent was employed as a registered nurse by Maxim Staffing Solutions and was assigned to work at Pleasant Valley State Prison located in Coalinga, California ("PVSP").

10. On or about April 4, 2011, at 1900 hours, Respondent found an inmate/patient ("I/P") in his cell with "no clothing on". At 1950 hours, the I/P flooded his cell and the hallway with water and attempted to flush his gown down the toilet, which led to more flooding. At 2050 hours, a custody team extracted the I/P from his cell as ordered by Dr. P. and had to use pepper spray during the extraction. At 2110 hours, the I/P was placed in 5-point restraints. Respondent noted in the Interdisciplinary Progress Notes that the I/P had a 1.5 inch laceration above his right eye. At 2200 hours, Dr. S. E. arrived in the unit and told Respondent not to send the I/P out for stitches and to place steri-strips over the I/P's right eye to close the laceration.

11. On or about April 5, 2011, at 0600 hours, registered nurse S. P., the morning shift nurse, took report from Respondent. S. P. discovered during Respondent's report that Respondent had failed to perform the 2 to 4 hour passive range of motion on the I/P at any time during her shift. S. P. told Respondent that it was against PVSP's policy not to perform range of motion on a patient in 5-point restraints. At 0630 hours, Respondent documented in the I/P's medical records, specifically, the Physician's Orders form, that on April 5, 2011, at 0015 hours, Dr. S. E. had issued a verbal order, "Do no range of motion until AM shift when more staff available". Respondent also made a late entry in the Interdisciplinary Progress Notes that on April 4, 2011, at 2200 hours, the "MD & SRNII" (supervising registered nurse II) had told her not to do the range of motion. Later, Dr. S. E. reported to PVSP staff (the Chief Psychiatrist, Chief of Mental Health, Chief Medical Officer, and Director of Nursing) that she never gave the verbal order to Respondent.

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12. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on and between April 4, 2011, and April 5, 2011, Respondent was guilty of gross negligence in her care of the I/P within the meaning of Regulation 1442, as follows:

a. Respondent failed to release or delegate or supervise the release of the I/P's 5-point restraints at any time during her shift.

b. Respondent wrote a physician's order that routine range of motion was not to be performed on the I/P, who was in 5-point restraints, when, in fact, the order had not been given or issued by Dr. S. E.

c. Respondent made false entries in the I/P's medical records by documenting on the Physician's Orders form and the Interdisciplinary Progress Notes that Dr. S. E. had issued an order or otherwise instructed her not to perform range of motion on the I/P. In fact, the order had not been given or issued by Dr. S. E.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

13. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 9 through 11 above.

14. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on and between April 4, 2011, and April 5, 2011, Respondent was guilty of incompetence in her care of the I/P within the meaning of Regulation 1443, as set forth in paragraph 12 above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

15. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 9 through 11 above.

16. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that on and between April 4, 2011, and April 5, 2011, Respondent committed acts constituting unprofessional conduct, as set forth in paragraph 12 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 504023, issued to Peggy Lee Martin, also known as Peggy Lee Denman;

2. Ordering Peggy Lee Martin, also known as Peggy Lee Denman, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: January 18, 2013

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2012106605